NANTUCKET
COTTAGE HOSPITAL

AUTHORIZATION TO RELEASE/ OBTAIN INFORMATION

1. I hereby authorize Nantucket Cottage Hospital to release/ obtain the following medical information from the health records of:

____ ____________________
Patient Name – please print Date of Birth

____
Address

____ ____________________
Zip Code Telephone #

Covering the period(s) of treatment for:
Hospitalization/ Observation – Admit Date:__________ Discharge Date:_________
ER – SDC – MP – Date of Service:___________

2. Type of Information to be released:
   - _____ Complete Record
   - _____ History & Physical Exam
   - _____ Discharge Summary
   - _____ Emergency Room Record
   - _____ Other (Specify)_________________
   - _____ Laboratory Results
   - _____ Radiology Reports
   - _____ Operative Report
   - _____ Pathology Report

3. Release information to: ____

____
Address Zip Code

4. Purpose of disclosure:____

5. I am not giving my permission for any re-disclosure of this information other than as specified above. This authorization is subject to my revocation at any time except to the extent that any disclosure made in good faith has begun. The hospital, its employees, officers and physicians are released from liability for release of this information to the extent indicated and herein authorized. I further understand this authorization pertains specifically to this release of information and upon completion will no longer remain in effect. I understand that I must provide a picture ID when picking up record copies.

_______________________________________ ______________
(Patient or Representative Signature) Date

____
(Relationship to patient)

_______________________________________ ______________
(Witness) Date